

# Medical Examination Report for a Disabled Dependant

Public Service Pension Plan (PSPP)

To provide medical information for a disabled dependant, after the death of an OPB client.

Complete page 1 before forwarding this form to the dependant's physician.

OPB client number

## OPB client information

OPB client last name (please print)	OPB client first name	Initials
<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of death (YYYYMMDD)		
<input type="text"/>	Attach proof of death, if not already provided to OPB.	

## Disabled dependant information (complete a separate form for each dependant)

Dependant last name	Dependant first name	Initials
<input type="text"/>	<input type="text"/>	<input type="text"/>

## Sign and date (keep copies of all completed forms for your records)

I authorize my/the dependant's physician, and any medical professionals referred to in this report, to release medical information about me/the dependant to OPB. OPB will receive, use and maintain such information solely for the purpose of evaluating my/the dependant's application for a survivor benefit.

I understand that if the medical information is not provided, I/the dependant may not qualify for a survivor pension.

	Date signed (YYYYMMDD)	Relationship to the dependant
	<input type="text"/>	<input type="text"/>

Signature of person completing form

Last name of person completing form	First name of person completing form	Initials
<input type="text"/>	<input type="text"/>	<input type="text"/>

## Physician must complete pages 2 and 3 and return to you for filing with OPB.

All medical information relates to the physical or mental condition of the disabled dependant, up to and including the date of death of the OPB client.

The physician or medical professional signing this form must be recognized as such by the appropriate governing medical association in Canada or the USA (e.g., Canadian Medical Association, American Medical Association). You are responsible for paying any fees required for complete this report.

The personal information on this form is collected under the authority of the *Public Service Pension Act* and will be used to administer pension benefits. For more information or if you have any questions, contact Client Services or our Privacy Officer at:

**Telephone:** 416-364-5035 or **toll-free** 1-800-668-6203 (Canada & USA) | **Fax:** 416-364-7578 | **OPB.ca**



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**Physician - complete pages 2 and 3**

An application for a survivor pension is being filed for the disabled dependant named below. Please complete pages 2 and 3 of this form, and strike out non-applicable areas. Return the completed report to the applicant. The applicant is responsible for paying any fees you may charge to complete this report.

**Pertinent information on which the medical opinion is to be based**

Under the Public Service Pension Plan, a disabled dependant must have a continuing mental or physical disability that makes them financially dependent, to be eligible for a survivor pension from the PSPP.

Dependant last name	Dependant first name	Initials
<input type="text"/>	<input type="text"/>	<input type="text"/>

1. At what age or date did the dependant's symptoms first become apparent?

2. When did you first start treating this dependant?	Treatment began (YYYYMMDD) <input type="text"/>
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3. Diagnosis (describe)

4. What is the cause of the dependant's condition?

5. Subjective symptoms

6. Objective findings



OPB client number

7. Prognosis (attach additional information as needed)

[Empty box for prognosis information]

**Physician's assessment**

From the information provided or known to me, I certify that:

- the dependant had a continuing mental or physical disability at the OPB client's date of death.
- the dependant's disability is likely to cause a financial dependence.
- the dependant's condition is unlikely to improve.

Is there a need for further examination?  Yes  No

Next examination (YYYYMMDD)

Disability code (if applicable)

**Sign and date**

Physician last name (please print)  Physician first name  Initials

Office address

City  Province  Postal code  Country (if outside Canada)

Certified specialist?  Yes  No If yes, indicate specialty

Date signed (YYYYMMDD)  Office telephone number

\_\_\_\_\_  
Physician signature

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